Health Sector in India – Need for Further Strengthening

The First Five Year Plan of India accorded high importance to healthcare, especially primary healthcare, by regarding health to be fundamental to national progress in the form of a resource for economic development. At the global level, the Alma Ata declaration of WHO in 1978 called on all governments to "formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors".

In addition to the larger discourse on improving health standards in the country, two immediate factors were instrumental in bringing a substantive focus on rural healthcare in the form of a flagship mission mode programme, National Rural Health Mission (NRHM) in 2004-05, with a clear objective "to address infirmities and problems across primary health care and bring about improvement in the health system and the health status of those who live in the rural areas"[1]. Firstly, at the turn of the century, the United Nations Millennium Declaration formulated the Millennium Development Goals (MDGs), among which targets related to health acquired prominence. Secondly, while the setting of specific, time-bound targets under the MDGs brought focus to national health related goals, the National Health Policy 2002 emphasised on the objective of achieving "an acceptable standard of good health amongst the general population of the country" by focusing on "the need for enhanced funding and an organisational restructuring of the national public health initiatives in order to facilitate more equitable access to the health facilities"[2].

In fact, it was the Bhore Committee Report (1946) which was the first comprehensive national health plan for India, the proposals of which required structural changes in the health sector, but which largely lay unfulfilled. No doubt, advancements were made during the 1980s when health outcomes improved through expansion of rural health infrastructure and strengthening of tertiary care. However, due to inadequate budgetary resources for healthcare, the policy has been selective and targeted. Thus, despite efforts, large gaps prevail in the provision of healthcare services in pursuance of the goal of Health for All. This paper attempts to discuss the gaps that have been there in policy framework and its implementation in health sector in India. It discusses how lack of prioritisation of budgetary resources for this sector has led to a neglect of healthcare in India and underachievement in terms of health outcomes. It highlights that with the changing fiscal architecture, there is a need for ensuring adequate emphasis on health sector, both at the Union level and at the level of States. Although the National Health Policy 2017 talks about laying emphasis on primary healthcare, there are a number of concerns which persist, such as increasing involvement of the private sector and lack of clear strategy towards strengthening public provisioning.

[1] The 11th Five Year Plan document
[2] National Health Policy, 2002 document

Health Indicators and Health Financing – Comparison of BRICSAM Countries

At the global level, India has been performing way below the other comparable economies like those in the BRICSAM grouping of fast developing economies. A comparison among these countries and among different States in India underscores the need for a sharper focus on healthcare in India and a broader framework for implementation of the policy.

In the Human Development Index (2015), India ranks 130 among 188 countries and falls in the category of medium human development countries. A comparison across the BRICSAM countries, which are large developing economies, India fares the poorest in terms of HDI ranking as well as other specific health indicators. For health indicators like infant mortality rate, maternal mortality rate and under-five mortality rate, India's performance is poorest among the BRICSAM countries. Although since the year 2000 there has been a lot of ground that India has covered in terms of these statistics, it stood as the worst performer in 2015 among these countries.

Table 1: Health Indicators across BRICSAM countries

Countries	Infant mortality rate (per 1000 live births)		Under-five mortality rate (per 1000 live births)		Maternal mortality ratio (per 100 000 live births)	
	2000	2015	2000	2015	2000	2015
Brazil	28.1	14.6	32	16.4	66	44
China	30.2	9.2	36.9	10.7	58	27
India	66.4	37.9	91.2	47.7	374	174
Mexico	21.6	11.3	25.6	13.2	77	38
Russian Federation	19.7	8.2	23.2	9.6	57	25
South Africa	54	33.6	75.3	40.5	85	138

Source: WHO, 2016

In terms of resources for the health sector, India provides the least among the BRICSAM countries. As per the WHO data, the government expenditure on health is lowest in India and the Out of Pocket (OOP) expenditure as percent of total expenditure on health the highest, which were more than 60 percent in 2014. According to one of the estimates, over 63 million people are pushed below the poverty threshold every year due to healthcare costs alone[3]. The

[3] As reported in the Draft National Health Policy 2015 document, which has been replaced by the NHP 2017

healthcare costs are exorbitant because of lack of public provisioning and presence of a large private sector. From the latest NSSO survey, 71st Round, we can get the average OOP expenditure on health by consumption quintiles[4].

Table 2: Average per capita OOP expenditure (in Rs.)

	1st quintile	2nd quintile	3rd quintile	4th quintile	5th quintile
Rural	582.8	664.7	675	919.3	1781.4
Urban	756.3	1148.2	1621.3	2218.4	3475.5

Table 3: Health Financing across BRICSAM Countries

Country	Total expenditure on health as a percentage of gross domestic product		General government expenditure on health as a percentage of total expenditure on health		Out-of-pocket expenditure as a percentage of total expenditure on health	
	2000	2014	2000	2014	2000	2014
Brazil	7.0	8.3	40.3	46.0	38.0	25.5
China	4.6	5.6	38.3	55.8	59.0	32.0
India	4.3	4.7	26.1	30.0	67.9	62.4
Mexico	5.0	6.3	46.6	51.8	50.9	44.0
Russian Federation	5.4	7.1	59.9	52.2	30.0	45.9
South Africa	8.1	8.8	40.8	48.2	13.7	6.5

Source: WHO, 2016

Progress and Gaps

The National Health Mission (NHM), which subsumed the National Rural Health Mission (NRHM) and the National Urban Health Mission (NUHM) as sub-missions, was initiated in 2013 to expand the primary healthcare service coverage across the country. Thus, both rural and urban areas were brought under the ambit of NHM. However, it is well acknowledged in the mainstream literature that although NRHM was successful in making affordable healthcare services reach the rural population, there are a number of gaps that persist.

Over the years, India has been able to achieve lower levels of mortality indicators from what they stood at in 2005. However, some of the data

[4] Ravi, Shamika, Rahul Ahluwalia, Sofi Bergkvist (2016), "Health and Morbidity in India (2004-2014)", Brookings India Research Paper

also shows that performance in some of the other indicators is deteriorating for some States. According to the latest NFHS 4 (2015-16) data some of the health indicators show deterioration as compared to the data in NFHS 3 (2004-05). The sex ratio in some of the States like Andhra Pradesh, Assam, Bihar, Haryana, Karnataka, Maharashtra, Madhya Pradesh and Tamil Nadu has gone down over the ten year period. For some parameters under maternal health also like "Mothers who had antenatal check-up in the first trimester" or "Mothers who had at least 4 antenatal care visits" the performance of States has deteriorated. Under child immunisation, we see a relatively worsened performance in some States over the NFHS 3 survey data.

Another trend that is visible is that the percentage of "births in a private health facility delivered by caesarean section" has increased over these two survey periods in almost all the States. On the other hand births in a public health facility have decreased over this period. This is largely a result of the increasing role of the private sector through mechanisms like public private partnership (PPP). In many cases, the institutional deliveries are outsourced to private sector. In many cases the C-section deliveries are completely avoidable, but because the costs and profit margins are higher, private facilities tend to encourage these. Given the high cost and risks to the pregnant woman, this increasing trend of C-section deliveries needs to be studied carefully. Some research studies[5] have identified lingering bottlenecks in the operation of the flagship programme NRHM/NHM:

- Although a large number of Community Health Centres (CHCs), Primary Health Centres (PHCs), and Sub-Centres (SCs) have been added, their functioning is still below requirement. The infrastructure is substantially short of Indian Public Health Standards (IPHS) norms. According to the Rural Health Statistics 2016, at the all-India level the percentage shortfalls from the required levels are – SCs (20 percent), PHCs (22 percent), CHCs (30 percent).
- There is shortage of human resource in public health institutions in almost all the States. At the all-India level the shortfalls are – specialists (81percent), doctors (13 percent), obstetricians and gynaecologists (77 percent).
- Referral and emergency transport system seems to be working quite efficiently in States like Madhya Pradesh, Jharkhand, Assam and Tamil Nadu. However, in most of the districts in Uttar Pradesh, Orissa and Jammu & Kashmir, the Mobile Medical Units are not working.
- Case load at district hospitals (DH) and sub-district hospitals (SDHs) could possibly be higher due to lack of human resources and infrastructural facilities at lower levels of health institutions.
- Quality of services is seriously affected by shortage of staff nurses at all levels of facilities.
- Although trained Accredited Social Health Activists (ASHAs) are recruited in all the States, in some States they are not trained properly and in some States even the guidelines for the selection of ASHA workers are not followed properly. The

[5] Prasad, Sinha, and Khan (2013), "Evaluation Study of the NRHM in seven States" (commissioned by the Planning Commission)

existing training infrastructure like medical colleges, nursing training institutes does not match the required level of infrastructure.

- No rationalisation of posting and transfer policies for medical and health management personnel which affect the credibility and sustainability of healthcare.

A bottleneck analysis done using the Tanahashi framework for systemic bottlenecks, identified six key bottlenecks under the NRHM, especially pertaining to maternal and child healthcare (RMNCH+A) interventions[6] –

1. limited availability of skilled human resources;
2. low coverage in marginalised communities with low skilled staff posting;
3. inadequate supportive supervision of front line workers;
4. low quality of training and skill building;
5. lack of focus on quality of services and
6. insufficient IEC on key family practices

Due to these bottlenecks the policy efforts have not been able to yield the desired results and a lot remains to be accomplished. This has been acknowledged by the government in the recent situation analysis[7] done as part of the National Health Policy (2017). It has been recognised that there is high degree of inequity in health outcomes and access to healthcare services in India, across different vulnerable groups and between and within States. The document notes that "even in States where overall averages are improving, marginalised communities and poorer economic quintiles of the population, especially in remote and tribal areas, continue to fare poorly"[8].

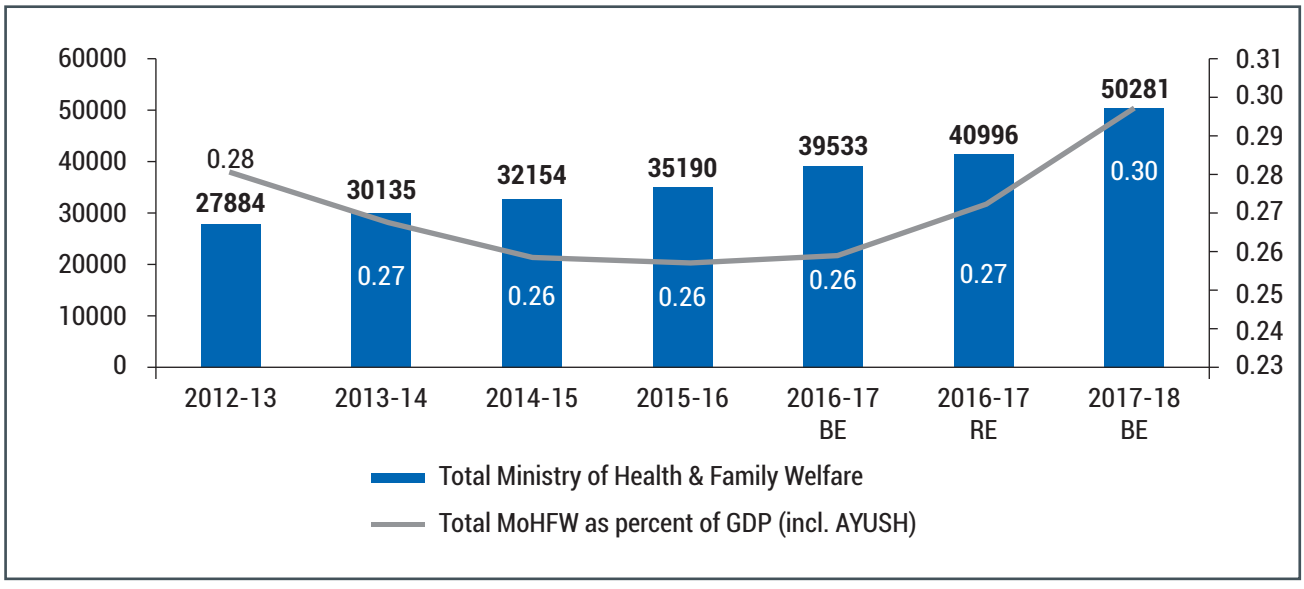
Thus, despite focused efforts to improve healthcare, especially primary healthcare, across the country through programmes like NHM, the inequalities persist across social groups as well as across geographic regions. One of the major reasons for non-achievement of targets is lack of financial resources for the health sector. This dearth of adequate funding translates into other shortcomings like inadequate human resources and infrastructure facilities across the country. The following sections discuss these issues in more detail.

Trends in Budgetary Allocations

For the health sector, one of the basic ingredients that has been lacking is adequate budgetary allocation. At the time of the launch of NRHM, the public spending on health was around 0.9 percent of GDP in the country. Over the next 10 years the combined Centre and States spending has increased to just about 1.2 percent, though the target set in the NHP 2002 was achieving at least 2 percent by 2010. However, as per official statement in order to achieve the stipulated targets in the health sector, the public expenditure would have to increase to 4-5 percent of GDP (Draft National Health Policy 2015)[9]. At present, the total allocation of Centre on health and family welfare amounts to just 0.3 percent of GDP (at current market prices) and the total Centre and States combined is around 1.2 percent.

[6] Ministry of Health and Family Welfare (2013), "A Strategic Approach to RMNCH+A in India"
[7] Ministry of Health and Family Welfare (2017), "Situation Analyses: Backdrop to the National Health Policy 2017"
[8] Ibid.
[9] This was noted by the Draft NHP 2015, but not mentioned in the ensuing National Health Policy 2017

Figure 1: Budgetary Allocation for MoHFW – Union Government



In the National Health Policy 2017, given the financial constraints, the target for total public expenditure on the health sector has been set at 2.5 percent of GDP, of which 40 percent should be from the Centre's expenditure. A simple calculation tells that, at the present level of GDP (current market prices), this 40 percent amounts to around Rs. 168474 crore whereas the present Central Government expenditure on health is a meagre Rs. 50281 crore, much less than even one-third of what is required /stipulated.

Health outcome indicators in India show that the MDG targets have not been achieved even after two years past the time limit. Moreover, a large section of the marginalised and poor population is dependent on the public health system which is over-burdened and under-financed resulting in high OOP expenses. In addition to these factors there are social and economic inequities in access to healthcare, all of which point to one direction that the public expenditure should be increased. According to one of the estimates by MoHFW, in response to the questions posed by the Departmentally-related Parliamentary Standing Committee on Health and Family Welfare, public health expenditure would need to increase by 147% in 2016-17 over 2015-16, for public health spending to touch 2.5% of GDP.

Under the total budget for health at the Union level, NHM comprises more than 50 percent. Although in absolute terms the allocation for NHM has increased, the trend of NHM as percent of total Union health budget has been declining since the beginning of the 12th Plan period from 65 percent in 2012-13 to 54 percent in 2017-18. As noted by the 93rd report of the Parliamentary Standing Committee, the total budget allocation made by the Union Government for NHM and for the Department of Health and Family Welfare over a period of five years (2012-13 to 2016-17) work out to a

measly 46.5 percent of the funding originally envisaged for NHM and the Department under the 12th Plan. The Committee also noted that the priority for NHM and the Health Sector "has been a soft target whenever the Government faces a resource crunch"[10]. The Ministry acknowledges that a shortfall of allocation under NHM from the projected outlay would affect a number of programmes. Although a number of steps have been mentioned to make good this shortfall, a lot has been left on to the States and it would be for the Centre to advocate with the States to increase their spending on health. With this, the Centre is transferring a number of responsibilities to the States, with the knowledge that not all States have adequate financial capacity to shoulder these.

14th Finance Commission Recommendations – Impact on Health Sector

In recent years, there have been some far-reaching developments in the fiscal-federal architecture in India. While, on the one hand, there has been increase in divisible pool of central taxes from 32 percent to 42 percent (on the basis of recommendations by the 14th Finance Commission), on the other, there have been reductions in Union Government's financial assistance to States for their Plan spending. In order to rationalise the Centrally Sponsored Schemes (CSSs), as recommended by a Sub-group constituted by the NITI Aayog, there have been changes in the Centre-State funding pattern across various CSS, among which there is National Health Mission (NHM) with the changed pattern in the ratio of 60:40 from the earlier 75:25. Given that the overall spending capacity of the States as a result of fiscal devolution is going to increase by a small extent and that they have a number of competing priorities to accommodate in their budgets, it raises a serious concern pertaining to the overall magnitude of budgetary resources that would be available for health sector interventions.

In Figure 2, we analyse the impact on health sector in the post 14th Finance Commission Recommendations period by comparing:

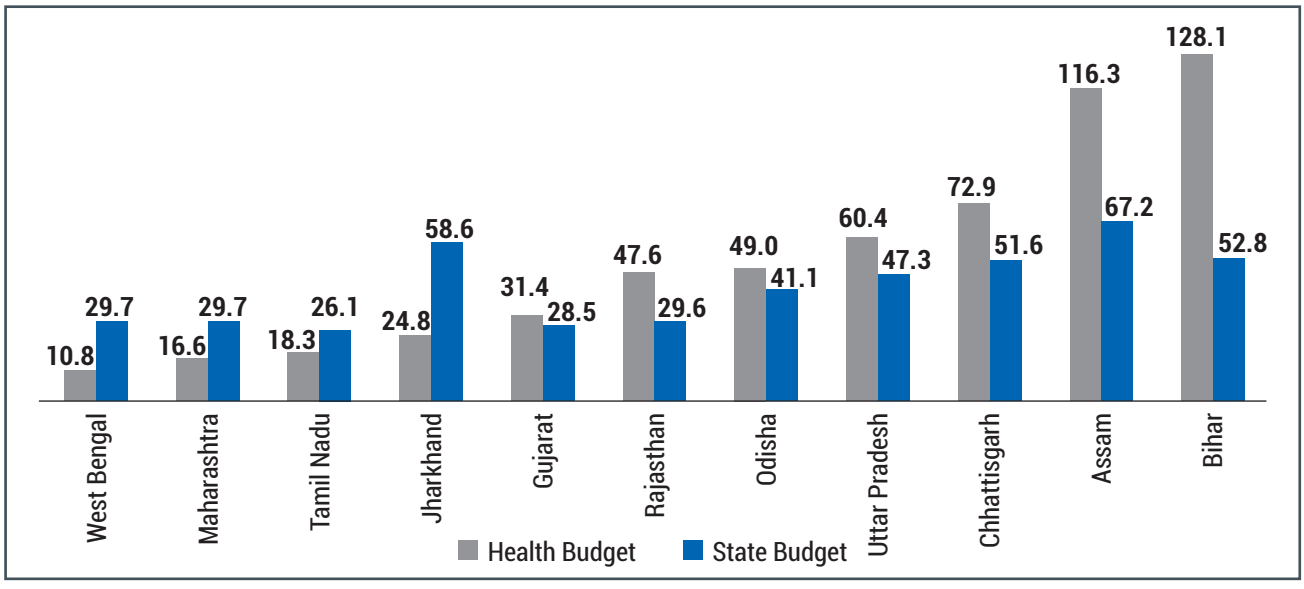
- Percentage increase in the total State Budget (i.e. total expenditure on all sectors) in 2016-17 (BE) over 2014-15 (Actuals); and
- Percentage increase in the budget (combined Central and State funds) for a specific sector in 2016-17 (BE) over 2014-15 (Actuals)

The analysis makes the assumption that if the extent of increase in the budget for a sector is significantly higher than the extent of increase in the overall budget of the State during the two year period, it reflects an increase in priority for the sector in the State concerned.

The analysis shows that in seven of the select 11 States the budgetary priority for health sector has increased more in comparison to the increase in total State budget. In two States – Bihar and Assam – the increase in health budget is significantly more than the State budget. In a few States like Maharashtra and Jharkhand, the budgetary priority for Health sector seems to have declined over the last two State Budgets – reflected in a lower percent increase in health budget as compared to total State budget.

[10] The 93rd Report of the Departmentally-related Parliamentary Standing Committee on Health and Family Welfare (2016-17)

Figure 2: Percent Change in State Health Budget & State Total Budget between 2014-15 and 2016-17



What is observed in these select States is that the sector that has witnessed a higher budgetary priority across most States is Urban Development and Housing. Thus, in the coming years there is a possibility that some States might not prioritise health sector in their budgets as much as is needed. In such a context, given the large scale inter-State and intra-State disparities in health indicators and public provisioning for health, the Union government would need to play a crucial role in stepping up budgetary resources for the sector by adequately funding the central programmes like National Health Mission (NHM).

It must be noted that in States like Bihar and Assam the State government has significantly prioritised budgetary resources for the health sector. If the Central allocation for NHM is taken out, the increase in State health budget, between 2014-15 and 2016-17, is 207 percent and 339 percent in Bihar and Assam respectively. This shows that in the post FFC period, some States are devoting more public resources to the health sector, while some States are not prioritising the health sector in their budgets.

Analysing only the NHM figures for States (Table 4), we see that over these two years – 2014-15 (Actuals) and 2016-17 (BE) – the increase in the allocation for NHM has varied across States. While in some States like Bihar the increase in NHM allocation is around 74 percent over the 2014-15 (Actuals), in States like Tamil Nadu, the increase is only 18 percent. In West Bengal the allocation under the NHM appears to have declined substantially during this period which needs to be probed further. This data shows that that there are variations across States in NHM allocation and supports the earlier analysis that different States would tend to prioritise different sectors. Under these circumstances the crucial sectors like health may suffer. Thus, the Union government would have to play an important role in order to address the regional disparity in the health sector.

Figure 3: Percent Change in States' contribution to Health Budget (excl. Central Allocation for NHM) between 2014-15 and 2016-17

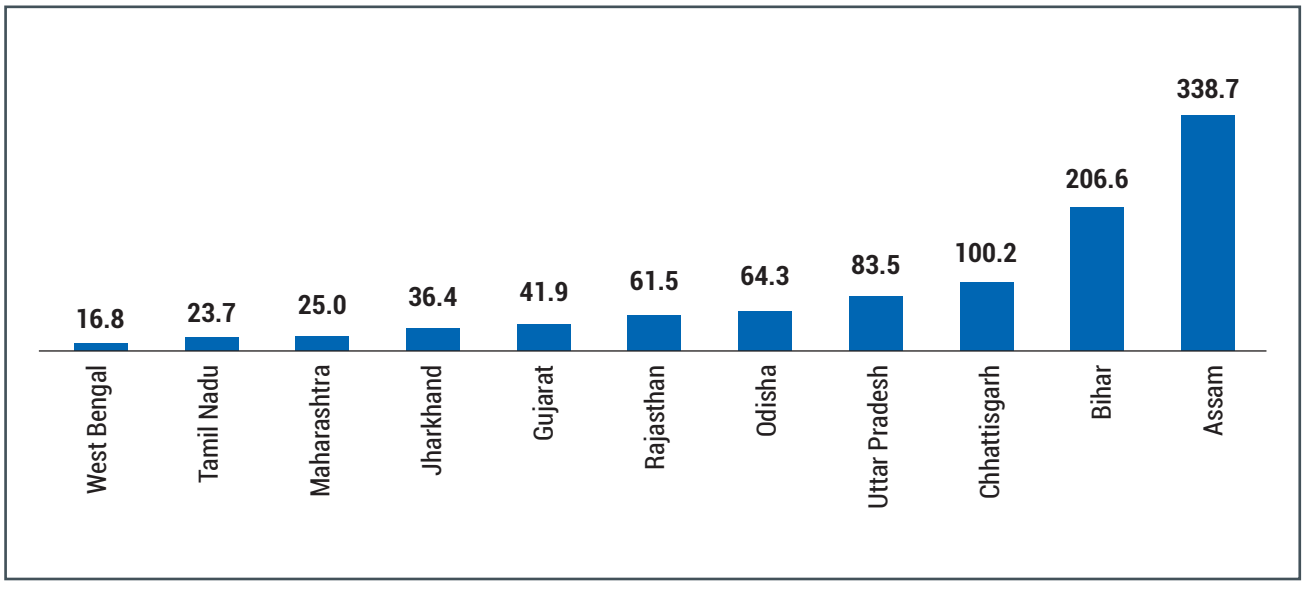


Table 4: Allocation for NHM across select States (figures in Rs. crore)

States	2014-15 (Actuals)	2015-16 (RE)	2016-17 (BE)	% change between 2014-15 and 2016-17
Bihar	984.6	1570.9	3769.7	73.9
Chhattisgarh	524.1	923.4	1003.7	47.8
Gujarat	964.0	1328.5	1378.9	30.1
Jharkhand	372.1	765.0	399.7	6.9
Madhya Pradesh	1233.0	1607.2	2088.8	41.0
Maharashtra	1327.7	2087.6	1322.8	-0.4
Odisha	804.2	1130.0	1379.4	41.7
Rajasthan	1334.6	2844.8	2872.3	53.5
Tamil Nadu	1405.5	1743.8	1714.5	18.0
Uttar Pradesh	3110.2	4674.0	5187.5	40.0
West Bengal	1622.2	1098.3	943.1	-72.0

Source: Annexure to Health Sector Financing by Centre and States/UTs in India (2014-15 to 2016-17)

Effective Delivery of Healthcare Services – Need for Adequate Human Resources and Infrastructure

Adequate availability of human resources and infrastructure are a prerequisite for a good quality healthcare delivery system. The High Level Expert Group (HLEG) Report[11] notes that for a universal healthcare system, with increased emphasis on primary healthcare as the core, there is a need for appropriately trained and adequately supported practitioners and providers located close to people, particularly for the marginalised communities.

The following tables (Table 5 and Table 6) show shortages in select personnel and infrastructure across select States. Although the reliability of Rural Health Statistics has been questioned, this is the only source of information for these parameters and does give an indicative picture of the extent of shortages existing in these key areas. Moreover, the surplus figures in some States needs to be looked at cautiously because here the surplus is as per national norms, but there maybe State specific norms which are higher. So, in reality there may be deficits when compared to the State norms.

Nonetheless, the shortages across different personnel category, such as specialists like Gynaecologists, are glaring across States and at the all-India level. For instance, in Maharashtra, the State norm is three doctors per PHC whereas the national norm is one doctor per PHC and the IPHS norm is two doctors per PHC. The shortfalls in each category are calculated as the difference between the required personnel and the personnel in-position in percentage terms. The shortfalls in infrastructure are calculated in a similar way.

Table 5: Shortfall in Select Human Personnel at different Facility Level across Select States (in percent)

	Health worker (female) / ANM at Scs & PHCs	Doctors+ at PHCs	Obstetricians & Gynaecologists at CHCs	Nursing staff at PHCs & CHCs
Bihar	*	1	93	34
Chhattisgarh	*	56	90	21
Gujarat	28	16	84	24
Jharkhand	*	17	79	36
Madhya Pradesh	*	19	76	1
Maharashtra	3	*	67	44
Odisha	*	27	59	64
Rajasthan	2	*	85	*
Tamil Nadu	21	*	86	*
Uttar Pradesh	*	37	85	50
West Bengal	*	21	87	*
All India/ Total	5	13	77	21

Note:*indicates surplus
The All India shortfall is derived by adding State-wise figures of shortfall ignoring the surplus in some States.
Source: Rural Health Statistics 2016

[11] High Level Expert Group (HLEG) Report on Universal Health Coverage for India, Planning Commission

Table 6: Shortfall in Infrastructure Facilities across Select States (in percent)

	Sub Centres	PHCs	CHCs
Bihar	48	42	81
Chhattisgarh	*	*	20
Gujarat	*	*	0
Jharkhand	35	66	22
Madhya Pradesh	26	41	33
Maharashtra	22	18	35
Odisha	18	1	*
Rajasthan	*	*	*
Tamil Nadu	*	*	*
Uttar Pradesh	34	33	40
West Bengal	21	58	35
All India/ Total	20	22	30

Note:*indicates surplus
The All India shortfall is derived by adding State-wise figures of shortfall ignoring the surplus in some States.
Source: Rural Health Statistics 2016

It has been pointed out that a number of States do not produce the requisite number of doctors, nurses or paramedics and they do not have the requisite budget to recruit quality human resources for health[12]. Also "implementation capacity of many States is slow particularly in respect of civil construction, procurement of drugs and equipment, engagement and management of human resources, paucity of health human resource such as doctors & specialists etc."

Way Forward

The recent policy documents and the public discourse point towards some fundamental issues as reasons for the ailing health sector in India. Low public expenditure and poor penetration of public healthcare services delivery, high out-of-pocket expenses, and a high reliance on private providers are characteristic features of Indian public health system. The requirements for physical infrastructure, human resources, financial resource allocation as well as concerns regarding the social and geographical inequities underlined by the National Health Policy (2002) in the beginning of this century still remain largely the same, as recorded in the recent National Health Policy 2017. The scarcity of public funds being allocated for health sector, both at the national and State level, get translated into human resource and infrastructure shortages which constrain the effective delivery of healthcare services.

Given the primacy of health, it should be regarded as a fundamental right just like education under the Right to Education Act. For

[10] The 93rd Report of the Departmentally-related Parliamentary Standing Committee on Health and Family Welfare (2016-17)

this to be accomplished, the basic measures that need to be taken are -

- Enhance the budgetary resource for health by both Centre and States. The Centre cannot absolve itself from the responsibility citing that public health is a State subject. Given the limited resources and competing priorities for these resources in States, Centre has to play a pro-active role to ensure that regional disparities in healthcare provisioning across States are not aggravated.
- Chronically low levels of public health resources, inadequate staffing and a freeze on regular appointments of medical staff have debilitated the system. Unregulated expansion of private healthcare services has also pulled specialists away from public medical service. Thus, it needs to be ensured that IPHS norms are adhered to in the provision of human resources and infrastructure at different levels of facility and the shortfalls are dealt with. Both the Centre and the States would have to work towards augmenting the human resources and infrastructure for healthcare.
- Private sector needs to be regulated in order to achieve the health goals. The government, instead of being a strategic purchaser of services from the private sector, needs to actively work towards ensuring public provisioning of healthcare in the country.
- As a large part of the OOP expenditure is owing to expenditure on medicines, the government needs to put in a rational drug policy in place. There needs to be regular prescription audit besides strict implementation of the Medical Council of India guidelines to prescribe only generic medicines.

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